Dr. Poane's Chiropractic Office
drpoane.com

Chiropractic Case History

Welcome to Our Office!

Today's Date _____

Name_____Address_____City_____Zip_____

Home phone_____ Cell phone: _____-_____ Birth date:_____ Age _____

Marital: M S W D Name of spouse _____ Emergency Contact Name and phone # _____

Who may we release your information regarding your personal health information, your bill, diagnosis, condition , treatment, test results: _____ Relationship: _____

Who is your family medical doctor? _____

Your E-mail:_____

We send appointment reminders and other notifications. Preferred method of contact: ___Email ___ Text ___Both

Are you pregnant: Yes / No

What medications are you taking now?_____ _____

If you are a new patient to our office, whom may we thank for referring you? _____

1. **What** symptoms or complaint brought you to our office? _____

2. **When** did your symptoms begin? _____

3. **FREQUENCY** of your Complaint, percent of the time: **Rare** = less than 10% of the time; **Occasional** = 10 - 25%; **Intermittent** = 25-50%; **Frequently** = 50-75%; **Constant** = 75-100%

4. **SEVERITY: Minor** = only a nuisance; **Mild** = difficult to live with; **Moderate** = very difficult to live with; **Severe**= extremely difficult to live with

5. **QUALITY:** How would you describe your symptoms? pain, dull ache, sharp, stabbing, burning, throbbing, tingling, numbness, other : _____

6. Do your symptoms **radiate** down your arm or leg? NO / YES

7. What activities **aggravate** your symptoms? drive, work, etc... _____

8. What gives **relief**? rest, ice, heat, sleep, medication? _____exercise, chiropractic, physical therapy, other _____

9. Circle the # that corresponds to your symptoms: no symptom or pain = **0 1 2 3 4 5 6 7 8 9 10** = severe symptoms/pain

10. **Place a check next to the activity that hurts or are difficult to perform because of the condition that brought you here:**

Personal Grooming:
_____ combing hair
_____ shaving
_____ in / out to bath tub
_____ brushing teeth

Housework:
_____ doing laundry
_____ making beds
_____ vacuuming
_____ washing dishes
_____ ironing
_____ carrying groceries
_____ caring for pets
_____ cooking

Travel: _____ minutes per day
_____ driving, auto, train, truck, airplane
_____ as passenger
_____ getting in and out of vehicle

Yard Work:
_____ mowing lawn
_____ shoveling (snow, dirt, mulch, sand)
_____ raking leaves
_____ gardening

General:
_____ walking
_____ standing
_____ running
_____ sitting

General:
_____ lifting children
_____ bending
_____ climbing stairs
_____ reading
_____ sleeping or lying in bed
_____ rolling over in bed
_____ swimming
_____ sports / hobby:
_____ using typewriter or computer
_____ kneeling
_____ using telephone
_____ exercising
_____ OTHER_____

_____ / 35 (36 w/other): This patient has pain or difficulty performing _____% of 35 (36) common ADL's.

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Biopsychosocial

Name:_____ Date: _____

Social :

1. What is your occupation?
2. Have you lost work because of this condition? ___ If yes, how many days or what dates? _____
3. Is this condition due to injury or sickness arising out of employment? _____ auto accident? ___ other?__
4. Do you exercise? If so, where and what type:
5. Do you smoke? no / yes packs / day? _____ No. of years? _____
6. Do you drink alcohol? no / yes = heavy moderate light times per week_____
7. Do you have small children: no / yes how many?_____
8. Have you ever been in an auto accident? No / yes = When?_____
9. Have you ever seriously injured yourself from a fall or other trauma? _____
10. What operations have you had and when? _____
11. Serious illness and when? _____

Circle your sleeping position(s): stomach, half stomach half side with one knee up, back, side
Do you sit at a desk frequently? Yes / No
Does your back hurt when you vacuum? Yes / No
Do you drive more than 20 minutes per day on the high way? Yes / No
Do you have to lift or reach for items (any items) on a daily basis? Yes / No

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REVIEW OF SYSTEMS:

Please explain any "YES" answers

Do you have or have you had significant problems with (your):

1. Eyes, ears, nose or mouth? no / yes _____
2. Heart or lungs? no / yes _____
3. Stomach, digestion (heart burn, indigestion, bloating), bowels, bowel movement or gastrointestinal tract? no / yes _____
4. Genitourinary system: please circle symptoms or conditions you now have or have in the past:
   Female: fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections, Heavy flow _____
   Male: urinary difficulties, difficulty stopping or starting urination, prostate enlargement, cancer etc?
5. Muscles, ligaments, bones, arthritis, ...? no / yes _____
6. Nerves, i.e. MS, pinched nerve, shaking, tripping, unsteady walk....? no / yes _____
7. Skin , sores, wound care, ...? no / yes _____
8. Psychiatric, i.e. bipolar, frequent depression,.....? no / yes _____
9. Do you seek professional counseling? no / yes _____
10 Is stress a factor in your life?_____
11 Hormone issues, lupus, autoimmune conditions, diabetes? _____
12 Blood or lymphatic problems? no / yes_____
13 Are you currently loosing weight for unknown reasons? no / yes _____
14.Do you have allergies or sensitivities to anything? no / yes _____
15 Other? _____

Family History:

1. Are there health related conditions that run or may run in your family, i.e. back problems, heart disease, cancer, alcohol, etc.. ? no / yes - explain:
2. Does or did your mother, father or siblings have allergies or sensitivities?

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Dr. Poane's Chiropractic Office
drpoane.com

Dr. Robert Poane
One Barrington Pl., Suite 108 Bel Air, Maryland 21014
410-420-7676

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment.

I, X_____, have received a copy of this office's Notice of Privacy Practices.
(please print your name)

X_____ X_____
(please sign your name acknowledging receipt) (today's date)

R. T. Poane, LLC attempted to obtain the patients acknowledgment of receipt of our Notice of Privacy Practices, but the Acknowledgment could not be obtained for the following reason: ___ Individual refused to sign ___ An emergency situation prevented us from obtaining the signature, ___ Other: _____

Dr. Poane's representative signature and date verifying that the patient did not sign the Acknowledgment:_____

Financial Policy

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize and direct the _____ insurance company to pay by check made payable to R. T. Poane LLC at One Barrington Place, Suite 108, Bel Air, Maryland 21014, the medical and surgical expense benefits allowable, and otherwise payable to me under my insurance policy, as payment towards the total charges for professional services rendered. To assist in collections, I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney in this case. I agree to pay, in a current manner, any balance of said professional service charge over and above this insurance payment (except where prohibited by contract). This is a direct assignment of my rights and benefits under this policy, of which a photo copy shall be considered as effective and valid as the original.

Any balance owed after 30 days shall accrue interest at a rate of 2% per month. Should collection efforts be required, I shall be responsible for reasonable attorney fees, court costs, and any out of pocket expense.

I understand that after two "No Show" appointments of not calling to cancel or reschedule an appointment, I will be charged a $25 fee.

I understand that I am ultimately responsible for payment in full to this office. I also understand that because of insurance delay's I may receive a bill months after my care has ended, but if I suspend or terminate my schedule of care, as determined by my treating doctor, fees for professional services will be immediately due and payable.

Please print your name: X_____ Today's date: X_____

I X_____ understand and agree to the Financial policy above.
(patient, guardian or parent signature authorizing care)

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1. It is my responsibility to know if my medical insurance (or other responsible party), will pay for chiropractic and other services or products I receive in this office.

2. I will not rely or depend on Dr. Poane's Chiropractic Office to determine what is covered by my insurance co..

The two sentences above are written in common language. I admit and confess I understand them to mean I am responsible for payment if my insurance or other responsible party does not pay for the care I choose to receive in this office.
Patient or guardian signature: X_____ Today's date: X_____

Dr. Poane's
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Informed Consent to Chiropractic Examination and Care

I hereby authorize Dr. Poane's Chiropractic Office and it's licensed doctors and registered assistants, based on my complaint(s) and history I will provide, to undertake an examination and treatment plan. Treatment plans may include but are not limited to chiropractic adjustments, massage, physical therapy, nutritional supplements and other tests and procedures considered therapeutically appropriate.

I may ask questions at anytime during the office visit. It is encouraged and expected that I address any concerns and or confusion about my diagnosis and care plan. To aid in the understanding of my condition, I understand pamphlets are located in various places in the office for me to read.

I am advised now that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjustments, manipulative procedures or treatment mentioned above are subject to rare but possible hazards or complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

Chiropractic is a "hands on" profession: chiro means "hands, "practice" mean practice. Chiropractors practice primarily with their hands; unlike a medical doctor who practices primarily with medicine. Therefore, during the examination and or treatment and or various reasons, it may be necessary for the examination and therapeutic procedures to be near and or contact with the breast, genitals, buttock, and other sensitive areas of the body. Prior to the examination or treatment, the doctor will inform me if and why there may need to be contact or exposure of sensitive areas. It is my responsibility to express my concern or refuse care involving any area that makes me feel uncomfortable. It is expected of me to communicate any concerns to the doctor or staff before or during such treatment, without fear or embarrassment or rejection.

I understand that chiropractic care in this office addresses the mechanical, emotional, and nutritional needs of patients. The thought processes, procedures, and therapeutic approach is considered holistic health and does not necessarily mimic the medical (pharmaceutical) model of health care.

I understand and accept that:

1. I have the right to withdraw from or discontinue care at any time.
2. Neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgements based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgement or treatment.
4. The practice does not guarantee as to results with respect to any course of care or treatment.

I have read this consent (or have had it read to me) and have the opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation, and risks to the proposed course of care and treatment by this practice.

Patient's Printed Name	Patient's Signature	Today's Date
Parent/Guardian Printed Name	Parent/Guardian Signature	Today's Date

Dr. Poane's Chiropractic Office
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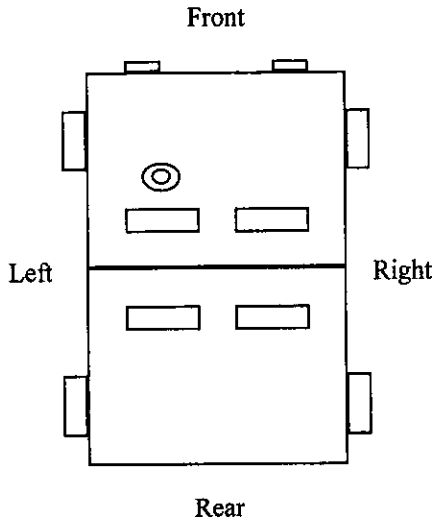
PAW Form

Personal Injury / Auto Accident / Workers Compensation

Name: _____ ***Date:*** _____

What was the date of the accident? _____



1. Place an arrow ***pointing to*** the area of the car where your vehicle was struck **OR** ***point the arrow away*** from your vehicle where you impacted something.
2. Place an **X** over the seat where you were sitting at the time of the impact.
3. Were you wearing your seat belt? Yes / No
4. What type of vehicle were you in? Car / Truck / Other _____
5. If you were hit from the rear, did you hit anything in front of your? No / Yes, I hit a _____
6. If you were hit, what type of vehicle hit you? Car / Truck / Other _____
7. What is the name of the vehicle you were in, i.e. Ford Taurus _____
8. Circle One: At the moment of impact, were you stopped or moving?
9. In your own words, please describe what happened: _____
10. Were you taken to the hospital? No / Yes, which hospital _____
11. How did you get to the hospital? Ambulance / Other _____
12. Did your head hit the head rest? No / Yes
13. Did the air bag deploy and hit you? No / Yes
14. Did you hit your head or chest on the steering wheel? No / Yes
15. Were there any projectiles in the car that hit you? i.e., books, purse, etc? _____
16. Were you rendered unconscious? No / Yes
17. How or what did you feel right after the accident? _____
18. When did you begin feeling symptoms, i.e., right away, minutes later, hours later, _____ days later
19. Since the accident, does your head feel too heavy for your shoulders? Yes / No
20. Since the accident, are you experiencing frequent headaches? Yes / No
21. Since the accident, are you more constipated or have loose stools? Yes / No
22. Since the accident, are you more irritable and snap at friends, family or coworkers? Yes / No
23. Since the accident, has your sleep been disturbed? Yes / No
24. Did you have any of these complaints before the accident? No / Yes, which ones: _____
25. Did you miss work because of the above injury? No / Yes and those dates are _____